



The Commonwealth of Massachusetts
Motor Vehicle Insurance - Merit Rating Board
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(617)267-3636 Fax (617)351-9660

MARY ANN MULHALL
DIRECTOR

TO: Massachusetts Merit Rating Liaisons
FROM: Mary Ann Mulhall, Director
DATE: December 28, 2005
RE: SDIP 2006 - Revised Safe Driver Insurance Plan Surcharge Notice Form
NOTICE NO: 0023

The Safe Driver Insurance Plan (SDIP) for 2006 requires a minor revision to the Safe Driver Insurance Plan Surcharge Notice form. The Commissioner of Insurance has approved the following revision.

Item (*) under the Surcharge Appeal Instructions on the front page of the Surcharge Notice form should be revised as follows:

* Filing a surcharge appeal does not prevent the application of the surcharge to the premium. If the surcharge is billed, it **MUST** be paid. If it is later reversed, your SDIP **data** will be adjusted, and the amount paid will be refunded or credited by the Insurance Company.

The word “step” in the 2nd sentence has been replaced with the word “data”.

Insurers are directed to begin using the revised form on notices issued on or after January 1, 2006.

Attachment

Cc: Kim Scott, Vice President and Chief Actuary, Automobile Insurers Bureau
Richard D. Hill, Assistant Director

Appendix S

SAFE DRIVER INSURANCE PLAN SURCHARGE NOTICE FORM

SAFE DRIVER INSURANCE PLAN SURCHARGE NOTICE					
The <u>(1)</u> <u>(2)</u> Insurance Company hereby notifies the OPERATOR named below that a surcharge will be imposed as required by M.G.L. c. 175 § 113B, as a determination has been made that the OPERATOR is more than 50% at fault for the accident described herein.					
This surcharge will result in an increase in premium when an insurance policy is next renewed for any vehicle on which the OPERATOR is listed.					
OPERATOR INFORMATION					
Name	(3)				
Address					
City, State Zip					
Date of Birth	(4)	Driver's License No.	(5)	State Code	(6)
♦ If any of the above operator information is incorrect, do not appeal. Contact your insurance company to make the appropriate corrections.					
ACCIDENT INFORMATION					
Accident Date	Surcharge Notice Date	Location Code	Policy No.	Claim No.	
(7)	(8)	(9)	(10)	(11)	
Standard of Fault Code <u>(12)</u> Explanation:					
(13)					
INSURANCE AGENT			POLICYHOLDER (if different than the OPERATOR)		
Name	(14)		Name	(15)	
Address			Address		
City, State Zip			City, State Zip		
			Date of Birth	Driver's License No.	State Code
			(16)	(17)	(18)
SURCHARGE APPEAL INSTRUCTIONS					
IF YOU BELIEVE YOU WERE NOT MORE THAN 50% AT FAULT IN THIS ACCIDENT AND WISH TO APPEAL TO THE MASSACHUSETTS DIVISION OF INSURANCE, YOU SHOULD:					
(A) Complete the Surcharge Appeal Form on the reverse side of this notice.					
(B) Send a check or money order for \$50.00 payable to the Commonwealth of Massachusetts. This filing fee is non-refundable. File only one appeal per accident. The Division of Insurance does not accept cash.					
(C) Return this completed form with the filing fee by mail to: <div style="text-align: right; margin-top: 5px;"> DIVISION OF INSURANCE P.O. BOX 370009 BOSTON, MA 02241-0709 </div>					
(D) A request for appeal must be submitted and received WITHIN 30 DAYS of the Surcharge Notice Date.					
(E) The Division of Insurance will notify you as the date, time, and location of your hearing.					
♦ Filing a surcharge appeal does not prevent the application of the surcharge to the premium. If the surcharge is billed, it MUST be paid. If it is later reversed, your SDIP data will be adjusted, and the amount paid will be refunded or credited by the Insurance Company.					
NAME _____					
If the operator's mailing address is different than the address shown above, please indicate corrections here → ADDRESS _____					
CITY, STATE ZIP _____					

Appendix S

SURCHARGE APPEAL FORM *(back of SURCHARGE NOTICE FORM)*

SURCHARGE APPEAL FORM			
The OPERATOR should provide as much of the following accident information as possible:			PLEASE PRINT
ACCIDENT INFORMATION	Time _____ : _____ <div style="display: flex; justify-content: space-between;"><input type="checkbox"/> AM <input type="checkbox"/> PMNumber of vehicles involved _____</div>	No. of lanes in each direction _____	
Location _____ <div style="display: flex; justify-content: space-between;">CITY/TOWNSTATESTREET</div>		No. of lanes in each direction _____	
If intersection, intersection street _____		Your speed prior to the accident _____ mph Posted speed _____ mph	
SIGHT LINES/DISTANCE When you first saw the other vehicle, how far were you from it? _____			
If a rear end collision, give distance between you and the vehicle you were following prior to accident. _____			
If an intersection collision, give your view in distance to right _____ to left _____ before entering intersection.			
POLICE _____ at accident scene? <input type="checkbox"/> No <input type="checkbox"/> Yes Were you issued a citation ("ticket")? <input type="checkbox"/> No <input type="checkbox"/> Yes			
DAMAGE (example – passenger side rear door) To the vehicle you were driving _____ To other vehicle _____ Identify damaged property other than vehicles _____			
BEFORE THE ACCIDENT YOUR CAR WAS <input checked="" type="checkbox"/>			LIGHT CONDITIONS <input checked="" type="checkbox"/>
<input type="checkbox"/> Going straight ahead <input type="checkbox"/> Making a right turn <input type="checkbox"/> Merging <input type="checkbox"/> Starting from parked position <input type="checkbox"/> Turning right on red <input type="checkbox"/> Changing lanes <input type="checkbox"/> Avoiding object in road <input type="checkbox"/> Making a U-turn <input type="checkbox"/> Overtaking another vehicle <input type="checkbox"/> Starting from stop sign <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Backing <input type="checkbox"/> Starting from traffic control <input type="checkbox"/> Slowing or Stopping <input type="checkbox"/> Other _____ <input type="checkbox"/> Making a left turn <input type="checkbox"/> Parked <input type="checkbox"/> _____			<input type="checkbox"/> Daylight <input type="checkbox"/> Dusk <input type="checkbox"/> Dark-Unlighted area <input type="checkbox"/> Dark-Lighted area <input type="checkbox"/> Other _____
TRAFFIC CONTROL <input checked="" type="checkbox"/>		ROADWAY SURFACE <input checked="" type="checkbox"/>	
<input type="checkbox"/> Traffic Light <input type="checkbox"/> None <input type="checkbox"/> Stop Sign <input type="checkbox"/> Construction area <input type="checkbox"/> Yield Sign <input type="checkbox"/> Officer/Guard <input type="checkbox"/> Flashing Light <input type="checkbox"/> Other _____		<input type="checkbox"/> Dry <input type="checkbox"/> Sand <input type="checkbox"/> Slush <input type="checkbox"/> Mud <input type="checkbox"/> Snow/Ice <input type="checkbox"/> Wet <input type="checkbox"/> Other _____	
WEATHER <input checked="" type="checkbox"/>		WEATHER <input checked="" type="checkbox"/>	
<input type="checkbox"/> Clear <input type="checkbox"/> Rain <input type="checkbox"/> Cloudy <input type="checkbox"/> Sleet/Hail <input type="checkbox"/> Fog <input type="checkbox"/> Snow <input type="checkbox"/> Mist <input type="checkbox"/> Other _____		<input type="checkbox"/> Clear <input type="checkbox"/> Rain <input type="checkbox"/> Cloudy <input type="checkbox"/> Sleet/Hail <input type="checkbox"/> Fog <input type="checkbox"/> Snow <input type="checkbox"/> Mist <input type="checkbox"/> Other _____	
PROVIDE DETAILS OF HOW THE ACCIDENT HAPPENED			ACCIDENT DIAGRAM
<div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 5px;"></div>			

Appendix S

Safe Driver Insurance Plan Surcharge Notice Form

Data Definitions

Field
Number

- 1 Insurance Company Name.** This field contains the insurance company name of the insurer that issues this Surcharge Notice.
- 2 (Insurance Company Code).** This field contains the 3-digit Insurance Company Code of the insurer that issues this Surcharge Notice.
- 3 Operator Information: Name.** This field contains the full name of the operator involved in the accident. When completing the name, do not omit “Jr.”, “Sr.”, “II”, etc. If the vehicle was unattended and involved in a downward grade collision, identify the person who last operated the vehicle.

Operator Information: Address. This field contains the street address, city, state and zip code of the operator involved in the accident.
- 4 Operator Information: Date of Birth.** This field contains date of birth of the operator involved in the accident.
- 5 Operator Information: Driver’s License No.** This field contains the operator’s driver license number exactly as it appears on the driver license.
- 6 Operator Information: State Code.** This field contains the code for the state, territory, country or Canadian province that issued the operator’s driver license from “Appendix M: State Code”.
- 7 Accident Information: Accident Date.** This field contains the date the accident occurred.
- 8 Accident Information: Surcharge Notice Date.** This field contains the date the loss amount for this accident was paid, and the Notice Date in the corresponding SDIP Claim Source Record.

Field
Number

- 9 Accident Information: Location Code.** This field contains the three-digit code for the incident location. Use the location code from the appendix for “Premium and Accident Town Tables” of the *Massachusetts Private Passenger Automobile Statistical Plan*. Refer to www.commauto.com. If the incident occurred outside of Massachusetts, use the appropriate Out-of-State Town Code.
- 10 Accident Information: Policy No.** This field contains the Policy Number by which this policy may be referenced in insurance company files.
- 11 Accident Information: Claim No.** This field contains the Claim Identification Number by which this claim may be referenced in insurance company files.
- 12 Accident Information: Standard of Fault Code.** This field contains the Standard of Fault Code from “Appendix J: Surcharge Code – Standard of Fault”.
- 13 Accident Information: Standard of Fault Explanation.** This field contains the complete description for the Standard of Fault Code displayed in field number 12.
- 14 Insurance Agent.** This field contains the full name and mailing address of the insured’s insurance agent. This field contains the full name and mailing address of the insurer if no insurance agent is involved.
- 15 Policyholder: Name.** This field contains the full name of the policyholder if the policyholder is not the involved operator. When completing the name, do not omit “Jr.”, “Sr.”, “II”, etc. Enter the value “SAME” in this space if the policyholder is the involved operator.
- Policyholder: Address.** This field contains street address, city, state and zip code for the policyholder identified in field number 15.
- 16 Policyholder: Date of Birth.** This field contains date of birth of the policyholder identified in field number 15.
- 17 Policyholder: Driver’s License No.** This field contains the policyholder’s driver license number exactly as it appears on the driver license.
- 18 Policyholder: State Code.** This field contains the code for the state, territory, country, or Canadian province that issued the policyholder’s driver license from “Appendix M: State Code”.